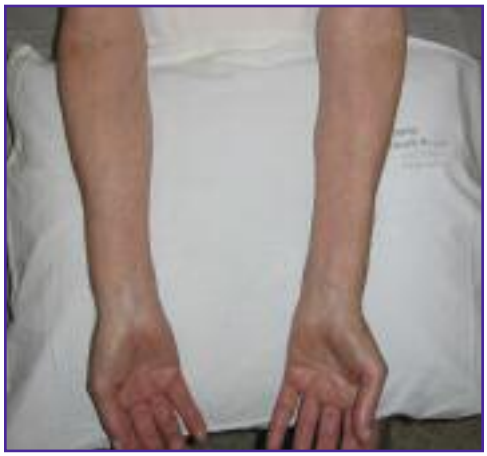
Case 1



Muscular Weakness

A 79-year-old man, diagnosed with lymphoma, presented with increasing weakness, tripping and difficulty opening jars and rising from chairs. He has no rashes.

Questions

1. What is the diagnosis?
2. How is it diagnosed?
3. How is the disease managed?

Answers

1. Inclusion Body Myositis (IBM) is the most common muscle disease in those over 50. It characteristically presents with forearm atrophy of the finger flexors, as well as quadriceps wasting.
2. It is diagnosed as a myopathic pattern on electromyography. Muscle biopsy provides the definitive diagnosis, with a characteristic rimmed vacuole inclusion body.
3. There is no disease-specific treatment available. The disease is slowly progressing. Swallowing studies for dysphagia, assistive devices and rehabilitation referrals are required.

Provided by: Dr. Paul Winston

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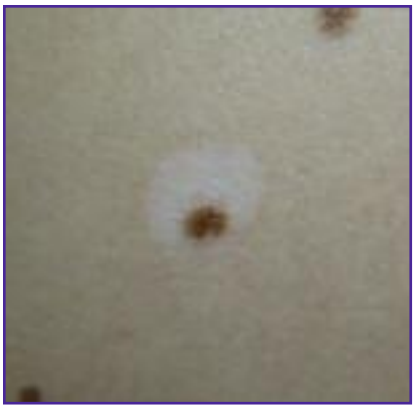
Case 2



White Ring on Back

A 15-year-old male presents with a white ring around a nevus on his back.

Questions

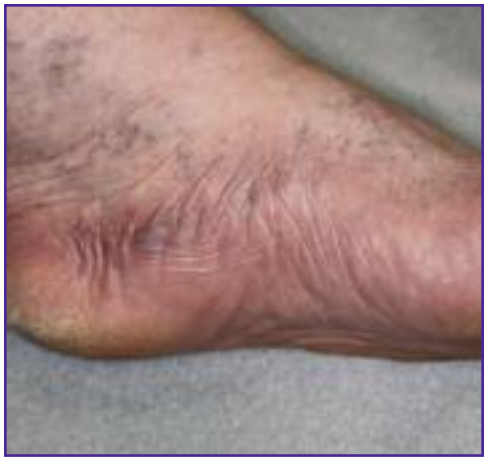
1. What is your diagnosis?
2. What is the potential concern with this type of lesion?
3. How would you manage this patient?

Answers

1. Halo nevus
2. Melanoma that is regressing can sometimes have a white halo or aspect to it, and thus should be ruled out.
3. Reassure patient as to the benign nature of this nevus. A biopsy should be considered if melanoma regression is in the differential diagnosis, otherwise cosmetic excision can be offered.

Provided by: Dr. Benjamin Barankin

Case 3



Scaling and Erythema of the Foot

A 48-year-old male presents with white scaling and erythema of the foot in a moccasin distribution.

Questions

1. What is the diagnosis?
2. What is the significance?
3. What is the treatment?

Answers

1. Tinea pedis; a dermatophyte infection that is promoted by the warmth and sweating caused by occlusive footwear. Tinea pedis results predominantly from *Trichophyton rubrum*, *Trichophyton mentagrophytes/interdigitale*, and/or *Epidermophyton floccosum*.
2. A variety of clinical presentations exist for tinea pedis. It can manifest as superficial white scales (moccasin-type tinea pedis, as in this case), interdigital opaque white scales and erosions (interdigital tinea pedis), vesicles or bullae (vesiculobullous type tinea pedis), and vesiculopustules and large areas of ulceration, which result from bacterial coinfection (acute ulcerative type). Often the clinical diagnosis of tinea pedis can be misleading, as the lesions can also be features of other skin diseases. Tinea pedis should be considered in the differential diagnosis of children with foot dermatitis, even though it is uncommon in prepubertal children.
3. Topical antifungals (terbinafine, ciclopirox olamine, itraconazole) are recommended treatments for mild infections. Systemic antifungals (terbinafine, itraconazole, fluconazole) may be required for more severe or recurrent infections, or failure of topical treatments.

Provided by: Ms. Jessica Corbin; and Dr. Richard Langley

Case 4

Facial Cellulitis

A 53-year-old woman comes to the emergency room for face cellulitis. A few days before, she had undergone root canal work at her dentist, with temporary closure and a prescription of oral penicillin.

Questions

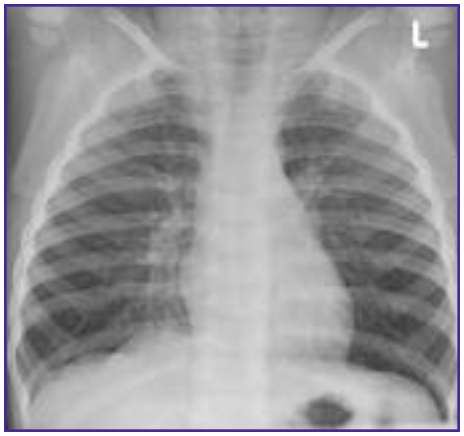
1. What is your diagnosis?
2. What is your treatment?

Answers

1. Facial edema secondary to a dental abcess; it is not cellulitis.
2. Surgical drainage is the treatment of choice. In this case, because she was on penicillin, a three day course of IV clindamycin is sufficient to control the progression of the abcess and to allow the completion of the root canal work by her dentist.

Provided by: Dr. Jean François Roussy

Case 5



Persistent Cough

A 15-month-old girl presents with a three week cough. Past health is unremarkable. The child is afebrile, not cyanotic, and not in respiratory distress. A chest X-ray is performed.

Questions

1. What is the diagnosis?
2. What is the significance?
3. What is the treatment?

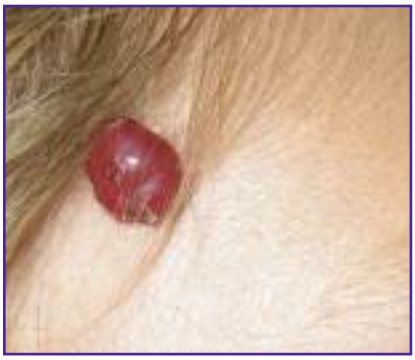
Answers

1. Eventration of the right hemidiaphragm
2. Eventration of the diaphragm is typically diagnosed by the finding of an abnormally elevated hemidiaphragm on chest X-ray. Clinically, eventration of the diaphragm may be asymptomatic or present with respiratory distress. The condition is rare, more common in males, and more often affects the left hemidiaphragm. Congenital eventration of the diaphragm is due to failure of muscularization of the diaphragm, wherein all or part of the muscle is replaced by a layer of connective tissue and few scattered muscle fibres. Most cases of congenital eventration of the diaphragm are sporadic and occur as an isolated finding. Occasionally, it may result from congenital rubella or cytomegalovirus infection. Congenital eventration of the diaphragm may also occur in association with Poland syndrome, Kabuki syndrome, Fryns syndrome, and Beckwith-Wiedemann syndrome.

   Acquired eventration of the diaphragm is caused by injury to the phrenic nerve with resultant paralysis and elevation of the diaphragm on the affected side. In the acquired condition, diaphragmatic atrophy results. Paradoxically, a paralyzed hemidiaphragm typically moves upward on inspiration and downward on expiration.
3. Asymptomatic eventration of the diaphragm can be treated conservatively. Symptomatic cases require surgical plication of the diaphragm, which can be performed via thoracoscopy or laparoscopy.

Provided by: Dr. Alexander K. C. Leung; Dr. Alexander A. C. Leung; and Dr. Justine H. S. Fong

Case 6



Red Papule on Temple

A 15-year-old female presents with a red papule on her temple which developed after squeezing a pimple.

Questions

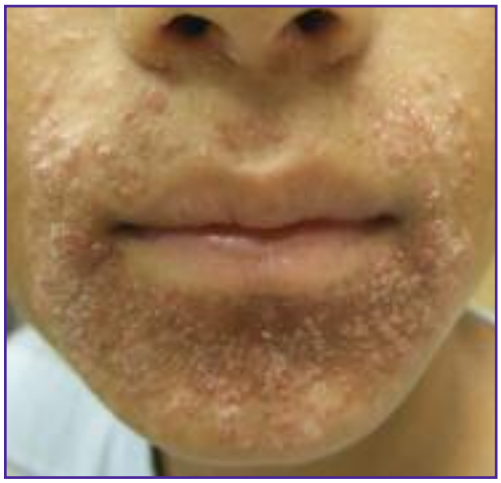
1. What is your diagnosis?
2. Which people are prone to this lesion?
3. How would you treat this person?

Answers

1. Pyogenic granuloma
2. Pregnant women, children, and patients on isotretinoin
3. Shaving the excision with electrocautery is quite effective. Cryotherapy and laser can be considered as well.

Provided by: Dr. Benjamin Barankin

Case 7



Facial Rash

A 12-year-old boy developed a "dermatitis" around his mouth and was treated with 1% hydrocortisone cream. The rash initially cleared, but then gradually worsened over a period of four months as he continued to use the topical corticosteroid.

Questions

1. What is the diagnosis?
2. What is the significance?
3. What is the treatment?

Answers

1. Perioral dermatitis; characterized by small discrete papules, vesicles and pustules with erythema and scaling. These eruptions predominantly occur around the mouth, often with sparing of the vermilion border. The rash may also appear around the nose and periorbital regions. As such, it is also known as periorificial dermatitis. It is commonly seen in young women and children of both sexes.
2. Topical corticosteroid use aggravates the eruption and worsens the symptoms, as in this case. Alternatively, there can be a steroid-dependent eruption, whereby discontinuation of the medication causes a flare.
3. Treatment includes immediate cessation of topical corticosteroids and initiation of oral tetracycline, minocycline or doxycycline for eight to ten weeks, with tapering for two to four weeks. Topical antibiotics (*e.g.*, metronidazole, erythromycin) can also be added, or in milder cases, can be used alone. Alternatively, pimecrolimus cream, a topical calcineurin inhibitor, is an effective treatment for steroid-induced perioral dermatitis. In cases with recurrent symptoms, long-term maintenance therapy with oral antibiotics may be necessary. Dx

Provided by: Dr. Andrea Herschorn; and Dr. Perla Lansang